Supreme Court, U.S.
FILED

No. 05-946

In The

Supreme Court of the United States

IRENE M. GESCHKE, INDIVIDUALLY AND AS EXECUTOR OF THE ESTATE OF CLARENCE O. GESCHKE,

Petitioner,

v.

AIR FORCE ASSOCIATION AND MONUMENTAL LIFE INSURANCE COMPANY,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Seventh Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED FOR REVIEW

Whether a federal appellate court may affirm a summary judgment entered in favor of a medical insurer despite controlling state law requiring ambiguous provisions in insurance policies to be construed in favor of insureds, including those paying for coverage against skyrocketing costs of medical treatments.

PARTIES TO THE PROCEEDING

Irene M. Geschke, Individually and as Executor of the Estate of Clarence O. Geschke; the Air Force Association; and Monumental Life Insurance Company.

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PETITION FOR CERTIORARI

Petitioner, Irene M. Geschke, respectfully requests issuance of a writ of certiorari to review the Judgment entered in this case by the United States Court of Appeals for the Seventh Circuit.

OPINIONS BELOW

The Seventh Circuit Court of Appeals selected its opinion in this case for publication in the Federal Reporter, where it is reported at 425 F.3d 337. The district court's unpublished memorandum opinion in this case is reprinted in the Appendix (App. 18-23).

STATEMENT OF JURISDICTION

Judgment was entered by the United States Court of Appeals for the Seventh Circuit on September 23, 2005. An order denying rehearing was entered by the Court of Appeals on October 20, 2005. Jurisdiction is based on 28 U.S.C. §1332 (App. 5-6) and §1291.

STATUTORY PROVISION

Rule 56 of the Federal Rules of Civil Procedure for the United States District Courts, 28 U.S.C.A.

STATEMENT OF THE CASE

The Petitioner's husband received from Respondent Air Force Association (hereinafter, "AFA") in April 1997 a letter and a brochure (in original record as R.46 Exhibits 6 and 7) promoting "CancerCare, our group cancer insurance plan." AFA's letter states that CancerCare pays "cash benefits" for "the many expenses associated with cancer *treatment*." (Emphasis added.) AFA's brochure states that CancerCare pays "Up to $500 for blood and plasma per illness period. *There is no maximum benefit for leukemia.*" (Emphasis added) (App. 3), and that "You and each of your insured family members are provided a lifetime benefit of $250,000." The brochure identifies the CancerCare plan's underwriter: Monumental Life Insurance Company, of Baltimore, Maryland.

Petitioner's husband enrolled himself and Petitioner in CancerCare, in May 1997. (App. 1-2) He was diagnosed with leukemia in March 1999, from which disease he died on June 21, 1999. (App. 3)

Petitioner resubmitted to Monumental in October 1999 her husband's claim for $37,622 in medical costs covered by the CancerCare plan. (App. 3) Of that amount, $33,689 related to her husband's treatments involving blood and blood plasma. (App. 1, 3) Monumental paid only $1,245 for those treatments. (App. 3) Monumental subsequently disclosed to Petitioner, for the first time, that where the CancerCare policy's "Blood and Plasma Benefit Rider" states that it pays a benefit for "incurred expenses for the cost of blood or blood plasma" that means that it "does not cover processing or administration fees, supplies, drugs, or laboratory charges associated with the cost of blood." (R.46 Ex. 35) (App. 3-4) But

this coverage limitation is not declared anywhere in the CancerCare promotional materials, CancerCare application form, certificate of coverage, or group policy.

Petitioner filed her first Complaint against Respondents in April 2002, in the Circuit Court of the Nineteenth Judicial Circuit, McHenry County, Illinois, alleging breach of contract and fraud. (App. 2, 4) In July 2002, Respondents removed the case on diversity grounds to the United States District Court for the Northern District of Illinois, Western Division, pursuant to 28 U.S.C. § 1332 (App. 4, 5-6).

Following discovery activity, Respondents filed in September 2003 a motion for summary judgment (App. 2, 4). The motion argued, *inter alia*, that the "cost of blood or blood plasma" language in the CancerCare policy "Blood and Plasma Benefit Rider" is unambiguous and thus as a matter of law Respondents are not liable for Petitioner's claims.

Petitioner had produced all of her documentary evidence to Respondents, who in turn attached copies of many of those documents, as well as excerpts from the transcript of Petitioner's deposition, to their statement of material facts. (R.46) Petitioner in turn drew that evidence to the district court's attention in her response to the summary judgment motion.

The district court granted Respondent's summary judgment motion in July 2004. (App. 4-5, 15-23) The district court agreed with the Respondents that the CancerCare plan's overall purpose was to provide insurance benefits "to help with the high cost of cancer treatment" but held that "treatment" was not covered by the blood and plasma benefit. (App. 20-21) After construing the phrase "incurred expenses for the cost of blood or blood

plasma," the court concluded that the benefit could only cover the cost of the actual blood product (App. 21-22), not the costs of matching the blood type to the patient and then transfusing it into the patient. The court "decided as a matter of law that the terms of the Blood and Plasma benefit are unambiguous in the manner that defendants have asserted." (App. 23)

After entry of summary judgment, Petitioner discovered that the AFA had at some point between July 12, 2003 and July 24, 2004 altered its website's description of the CancerCare policy's Blood and Plasma Benefit as providing "up to $500 per illness period of actual charges for blood or blood plasma" to "up to $500 per illness period of actual charges for *pints of* blood or blood plasma." (Emphasis added.) Petitioner conveyed this new information to the district court in a Rule 59(e) motion for rehearing, which the court denied: "AFA's changes to its website discovered by the plaintiff post-judgment, do not show the contract language to be ambiguous." (App. 24)

Petitioner appealed the summary judgment to the Court of Appeals for the Seventh Circuit, drawing that Court's attention to her evidence in support of her claim to benefits under the Blood and Plasma Rider. The Seventh Circuit affirmed the summary judgment in favor of the Respondents. (App. 14)

ARGUMENT

The Seventh Circuit reviewed *de novo* the summary judgment entered in favor of Respondents, "employing the same methodology as the district court." (App. 8)

Accurate Reading of CancerCare Policy Supports Finding of Ambiguity in Language "Incurred Expenses for the Cost of Blood or Blood Plasma"

To support the district court's conclusion that the phrase at issue here – "incurred expenses for the cost of blood or blood plasma" – was not ambiguous "as a matter of law" (App. 23), the Seventh Circuit began by engaging in a sophisticated analysis of how the CancerCare plan group insurance policy's riders are, according to the Court, in fact separate and independent from the policy itself. But that notion is contradicted by the plain language of the policy (including its riders).

For example, the Court refers to the policy's "Extended Hospital Expenses Benefit Rider" as a "special rider" that "was available" and "that did, under limited circumstances, provide coverage for cancer treatment." (App. 10-11) That rider is not "special": The Court's assertion is contradicted by its earlier affirmation (App. 2-3) that "The [CancerCare] *policy* and its associated *riders* provided defined benefits for certain *expenses incurred in the treatment of cancer, such as hospitalization, hospice care, ambulance services, anesthesia, and blood and plasma*." (Emphases added.)

Nothing in that rider says or implies that a policyholder had a "choice" (App. 11) between benefits specified by that rider or "all other benefits provided under the policy." (App. 11) Nothing in the record (and the Court does not point to anything there) supports the idea that anyone enrolling in the CancerCare plan could have separately "purchased the Extended Hospital Expenses rider." (App. 11) No one "purchased" a CancerCare policy – which of course was a group insurance policy – and no one then proceeded to select from a menu of riders available

for purchase. There was but one CancerCare group insurance policy and those who enrolled in it became covered by all riders to the policy.

Similarly, the Court attempts to separate out the Blood and Plasma Benefit Rider by observing that "Only the blood products [i.e., blood and plasma] are mentioned in the [Blood and Plasma Benefit] rider." (App. 10) Well, so are "expenses for the cost of," so where does the Court's reasoning lead?

Finally, every one of those CancerCare plan policy riders specifically states that it "is a part of the policy to which it is attached." (Riders attached as Ex. D to Petitioner's Opening Brief to the Seventh Circuit) All the language in all of those riders relates back to the policy's terms and coverages. "All the provisions of an insurance contract, rather than an isolated part, should be read together to interpret it and to determine whether an ambiguity exists." *United States Fire Insurance Co. v. Schnackenberg*, 88 Ill.2d 1, 5, 429 N.E.2d 1203, 1205, 57 Ill.Dec. 840 (Ill. 1983). (App. 8-9)

So clearly the CancerCare plan group insurance policy is all about providing benefits for specified costs of treating cancer.

(The Court also engaged in the useless exercise of defining two terms – "blood" and "plasma" – whose meaning Petitioner had never disputed. [App. 10])

There is a complete absence of any support for the Court's holding that "the phrase '[incurred expenses for the] cost of blood or blood plasma' means the cost of blood or plasma only and not the additional costs associated with treatment-related services such as laboratory testing and transfusion." (App. 10)